

Emergency Preparedness: Cross-Sector Coordination

NACCHO Annual Pre-Conference Workshop
Memphis, Tennessee
July 14, 2010

Public Health Law Program
Centers for Disease Control and Prevention
Atlanta, Georgia
www.cdc.gov/phlp



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Cutting-Edge Legal Preparedness for Chronic Disease Prevention



Public Health Grand Rounds
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Mutual aid agreements can be effective tools to assist U.S. state and local governments, Tribes, Canadian provinces, First Nations, and Mexican states in sharing information, data, supplies, resources, equipment, or personnel for the purpose of protecting the public's health. Resources which can be accessed here include:



[A Menu of Suggested Provisions for Public Health Mutual Aid Agreements](#)



[An Inventory of Mutual Aid Agreements and Related Resources](#)

There are currently several agreements in the works; please visit often to get the updates. All current additions will be posted and highlighted on this page (under "new" in the box to the right).

If you have any questions or just want to chat about Mutual Aid, drop me a line!

Dan Stier, JD

email: dstier@cdc.gov

Phone: 404.639.4680

New Stuff

Mutual Aid Agreement Between New England States and Canadian Provinces Receives Congressional Approval

The mutual aid agreement discussed below was signed into law by the President on December 26, 2007.

On December 17th, the House of Representatives passed House Joint Resolution 59, a companion to Senate Joint Resolution 13, which had earlier been passed by the Senate. The Joint Resolutions provide Congressional approval of the International Emergency Management Assistance Memorandum of Understanding (IEMAMOU), a mutual aid agreement executed in 2000 by the States of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, and the Provinces of Labrador, New Brunswick, Newfoundland, Nova Scotia, Prince Edward Island, and Quebec.

[more](#)



“Many public health preparedness plans include law enforcement – yet most law enforcement professionals are not aware of this and, more importantly, do not see a role for themselves in a public health crisis.”

William Bowen, Commander (retired)
Albany, New York, Police Department

Source: Bowen WT. Law enforcement and public health. *The Police Chief*.

2007;74(8).

Judges and Public Health

An Introduction to Public Health Law and
Science

State College, Pennsylvania

May 11 – 14, 2009



Public Health Law Program

Public Health “bench books” for the judiciary

http://www2a.cdc.gov/phlp/port_bench.asp



PENNSYLVANIA PUBLIC HEALTH LAW BENCHBOOK

DEVELOPED BY THE
ADMINISTRATIVE OFFICE OF
THE PENNSYLVANIA COURTS
THE UNIVERSITY OF PITTSBURGH
CENTER FOR PUBLIC HEALTH
PREPAREDNESS

DECEMBER 2006

 University of Pittsburgh
Graduate School of Public Health
Center for Public Health Preparedness

SUPREME COURT OF PENNSYLVANIA



ADMINISTRATIVE OFFICE OF PENNSYLVANIA COURTS

DRAFT

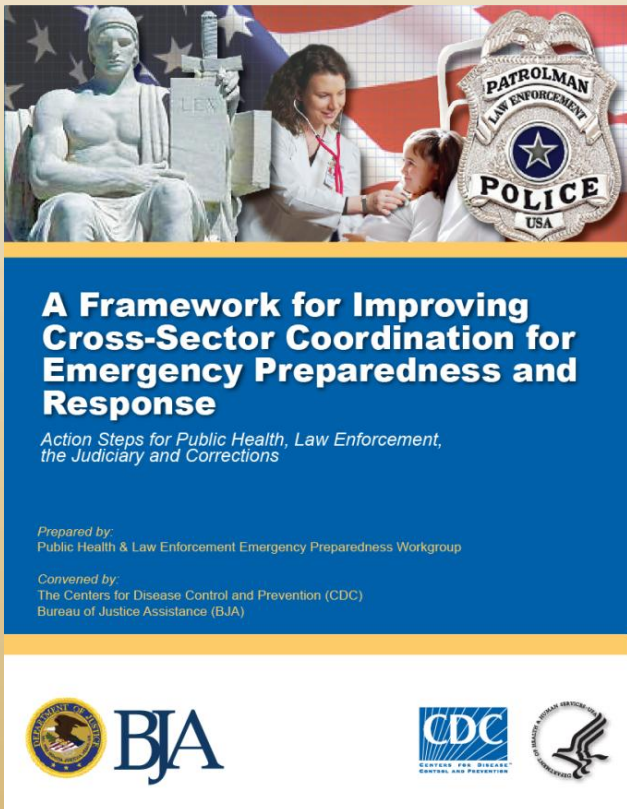
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DRAFT

Session Focuses on New Legal Preparedness Tools Developed by: Public Health and Law Enforcement Emergency Preparedness Workgroup

1.



2. *Model MOU for Joint Public Health and Law Enforcement Investigations*

3. *Guide to Developing an MOU for Coordinated Implementation of Community Response Measures to Pandemic Respiratory Disease*

This Session Will:

1. Provide you with information on these new practice-oriented tools for improving multi-sector coordination with non-traditional partners and legal preparedness for all-hazards emergencies
2. Familiarize you with each tool's purpose, organization, and contents
3. Initiate your consideration of how these tools might be adapted for use at state, tribal, and local jurisdictional levels within your state



Public Health and Law Enforcement Emergency Preparedness Workgroup

- With COTPER resources, established during 2007-08 by CDC's Public Health Law Program in partnership with DOJ's Bureau of Justice Assistance
- Composition included experts from local, state, and national organizations representing sectors of public health, law enforcement, corrections, and the judiciary
- Produced tools designed to foster improved multi-sector coordination for public health emergency preparedness and response



Workgroup's Partner Organization Representatives

- CDC (PHLP, DGMQ, CCID)
- DOJ Bureau of Justice Assistance
- DOJ Counterterrorism Section
- U.S. Department of Homeland Security
- National Association of Attorneys General
- City, county, university, and transit police departments
- State departments of public safety
- Association of State Correctional Administrators
- FBI WMD Directorate
- ASTHO
- NACCHO
- CSTE
- Association of Public Health Laboratories
- Office of ASPR HHS
- National Center for State Courts
- Administrative Office of the U.S. Courts
- National Institute of Corrections

Intent of These Tools

- Within a given jurisdictional setting (i.e., state, tribal, and/or local) to serve as a means to:
 - Bring to the table representatives of the relevant sectors,
 - Facilitate more complete understanding of each sector's roles and duties, in relation to the other sector(s), in preparing for and responding to certain types of public health emergencies, and
 - Accomplish these purposes in a manner that can be agreed upon by each sector and possibly viewed as binding.





A Framework for Improving Cross-Sector Coordination for Emergency Preparedness and Response

Action Steps for Public Health, Law Enforcement, the Judiciary and Corrections

Prepared by:
Public Health and Law Enforcement Emergency Preparedness Workgroup

Convened by:
Centers for Disease Control and Prevention

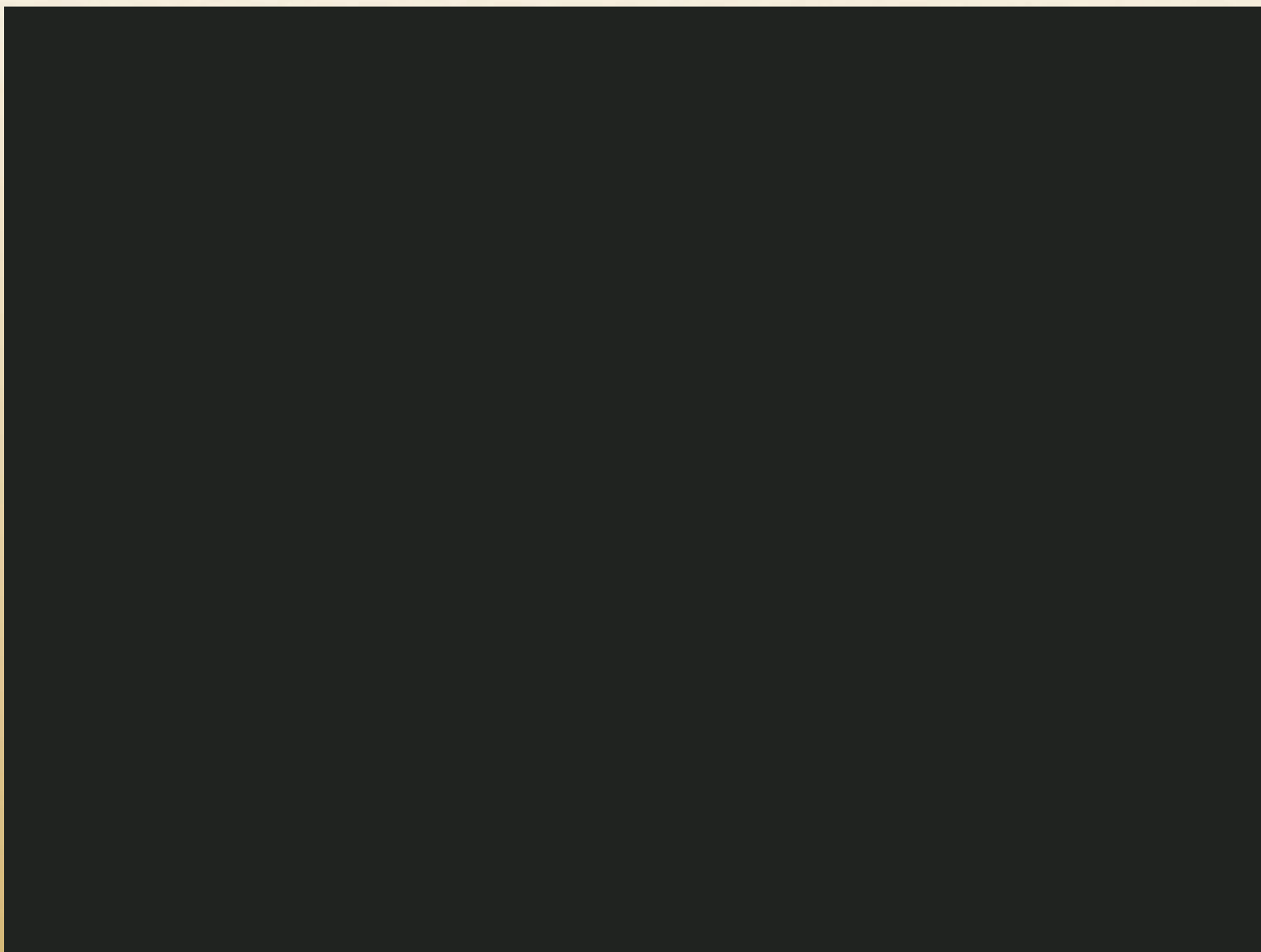
AND
Bureau of Justice Assistance

- A strategic rationale and resource for improving cross-sector coordination in preparedness
- Over 50 action options under four priority areas:
 - Organizing to implement opportunities for action
 - Roles and responsibilities
 - Communications and information-sharing
 - Training, education and exercises



BJA Bureau of
Justice Assistance





Model MOU for Joint Public Health and Law Enforcement Investigations

Joint Public Health – Law Enforcement Investigations: Model Memorandum of Understanding (MOU)

July 2008

Developed by:

**Public Health and Law Enforcement Emergency Preparedness
Workgroup**

Convened by:

**Centers for Disease Control and Prevention, DHHS
Bureau of Justice Assistance, USDOJ**

Is That an Epidemic — or a Terrorist Attack?

Bioterrorism Is the Least of Our Worries

By Jonathan B. Tucker

The news media are fascinated with bioterrorism. After a New Yorker article this week quoted unnamed Central Intelligence Agency analysts who speculated, apparently wrongly, that the outbreak of West Nile-like fever in New York could have been the work of Iraqi terrorists, a number of television news programs reported the story. And earlier this month, ABC's "Nightline" aired a weeklong docudrama in which a hypothetical anthrax attack on the subway system of a major city inflicts more than 50,000 deaths.

This sort of worst-case scenario is extremely unlikely. In truth, most terrorists aren't interested in staging catastrophic biological attacks, and those who are would have significant technical hurdles to overcome.

Over the past century, not a single

provide technical help, but only at grave risk: the sponsor could lose control over the terrorists and invite severe retaliation if its involvement became known. Or a wealthy terrorist group might try to recruit scientists formerly employed by the Soviet Union, for example, which had advanced bioweapons programs. But no evidence currently available points to such assistance.

Without technical help, small terrorist cells would have a hard time mounting a large-scale biological attack. Germs suitable for warfare are difficult to mass-produce and even harder to disseminate effectively. Microbes might be spread, for example, as an aerosol cloud, but it is technically complex and dangerous to produce a concentrated aerosol that could infect thousands of people. Contaminating urban water supplies is also beyond the ability of most terrorists, mainly because a huge volume of harmful agent would be needed to overcome the effects of dilution, chlorination and filtration.

In the late 1980's in Japan, the Aum Shinrikyo cult, which had vast financial resources, recruited scientists from leading Japanese universities to develop bioweapons. But even though the cult acquired anthrax bacteria and botulinum toxin and carried out several attacks in Japan, no injuries or deaths were reported. The cult then resorted to sarin, a chemical nerve agent. In March 1995, the group released the poison on the Tokyo subway, killing 12 people and injuring more than a thousand.

Given the constraints, a bioterrorist attack in the United States in which thousands of people are killed remains extremely unlikely. While planning for such an event is warranted, government authorities should pay attention to a far more probable scenario: small-scale incidents involving food or drug contamination, which could cause widespread fear and economic disruption. □



A Lethal Weapon We Must Learn to Recognize

By Jessica Stern

The flurry of rumors last week about the origins of the encephalitis outbreak in the New York metropolitan area proved how anxious we are about biological terrorism.

After an article in The New Yorker quoted unnamed Central Intelligence Agency sources who speculated that the West Nile-like virus might have been spread in an Iraqi biological attack, the C.I.A. found itself having to reassure the public that this chain of events was highly unlikely.

And indeed, it is.

For one thing, West Nile enceph-

Jessica Stern, a fellow at Harvard's Center for Science and International Affairs, is the author of "The Ultimate Terrorist."

litis is a relatively mild disease, and Saddam Hussein has far more virulent agents in his arsenal. For another, the outbreak has all the earmarks of a naturally occurring infectious disease, according to the Centers for Disease Control and Prevention.

But this case illustrates one of the most troubling aspects of biological terrorism: it can be extremely difficult to distinguish germ warfare from a natural outbreak of disease.

After all, this is not the first time that biological attacks have been blamed for sudden epidemics. In 1997, when foot-and-mouth disease struck pigs in Taiwan for the first time in 83 years, the Taiwanese Government was forced to slaughter some four million hogs. Taiwanese farmers, without any evidence, suspected that China had deliberately introduced the disease on the island to damage the economy.

After Cuba suffered an epidemic of dengue fever in 1981, it accused the United States of biological ag-

gression. In 1997 Cuba made a similar claim, charging that the United States had dropped crop-eating pests from a low-flying plane.

On the rare occasions when biological weapons have been used or accidentally released, scientists and government officials often first assumed that the epidemics were natural outbreaks.

Our uncertainty
about a virus's
origin is a
warning.

For instance, many American security experts initially believed that a 1979 outbreak of anthrax in the Soviet Union was caused by contam-

NY Times, Oct. 16, 1999

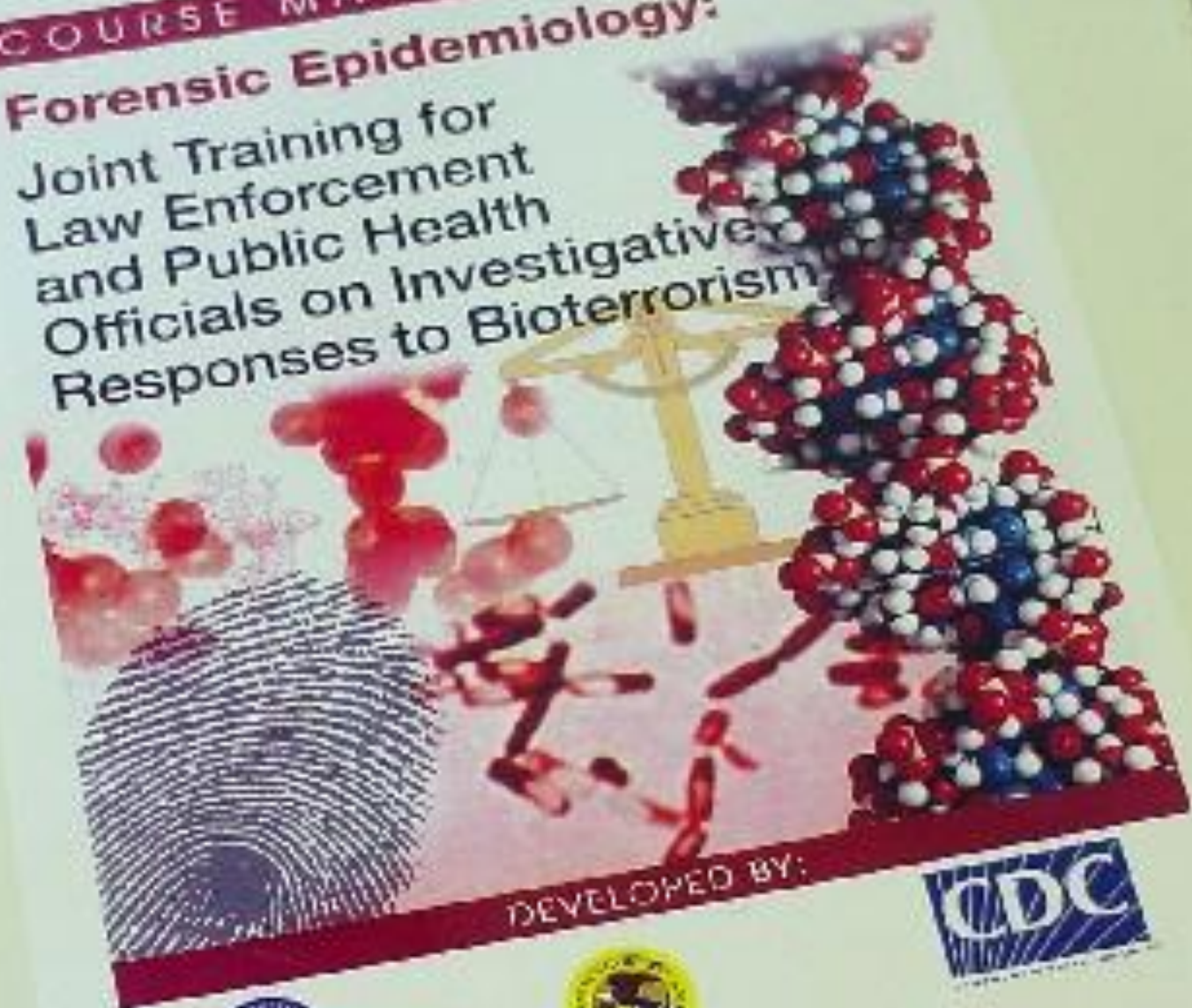


Kenneth Lambert / AP

COURSE MANAGER'S GUIDE

Forensic Epidemiology:

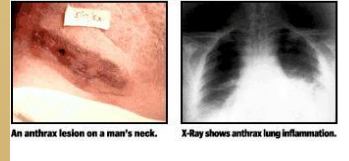
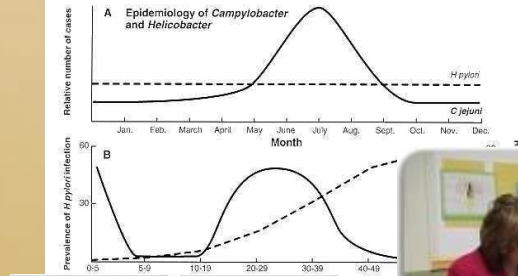
Joint Training for
Law Enforcement
and Public Health
Officials on Investigative
Responses to Bioterrorism



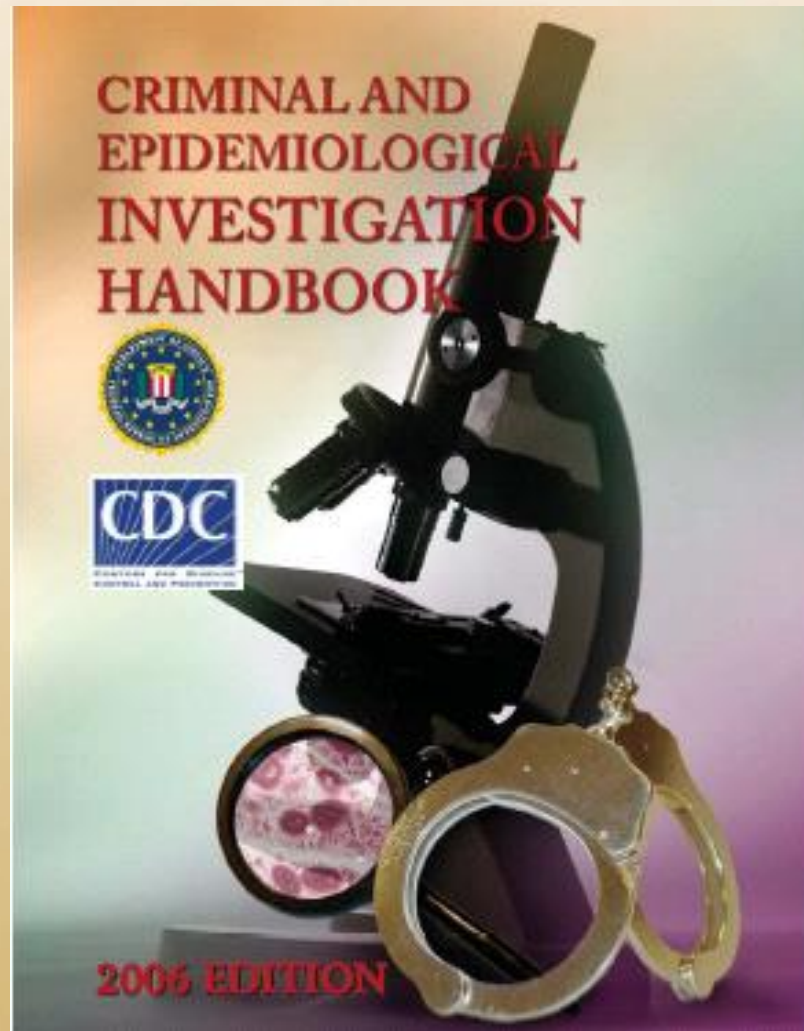
DEVELOPED BY:



FBI-CDC JOINT INVESTIGATIONS TRAINING



CDC and FBI Jointly-developed:



New York Report

The New York Times

City and F.B.I. Reach Accord On Bioterror Investigations

By JUDITH MILLER

The New York Police Department, the F.B.I. and the city's health department have agreed for the first time on a set of rules that will govern investigations of suspected biological attacks in the city, detailing the roles the agencies will play as well as how confidential medical information is to be shared.

The "protocol," a six-page document that officials regard as something of a remarkable cooperation agreement, resulted in part from lessons learned in New York during the 2001 anthrax letter attacks, which killed five people in Florida and the Northeast and infected more than a dozen others in the months after the Sept. 11 strikes.

The anthrax investigations, and several subsequent inquiries into suspected germ attacks, were strained by tension between health and law enforcement officials over turf and procedures.

The accord, which was worked out in confidential, sometimes contentious meetings over the last two years, states that while law enforcement officials have the lead in investigating any terrorist crime, such investigations must be conducted jointly with the Department of Health and Mental Hygiene since physicians are likely to be the first to identify a victim of a germ attack.

To aid that effort, the protocol agreement details some novel compromises among agencies that sometimes have competing interests.

For instance, law enforcement officials,

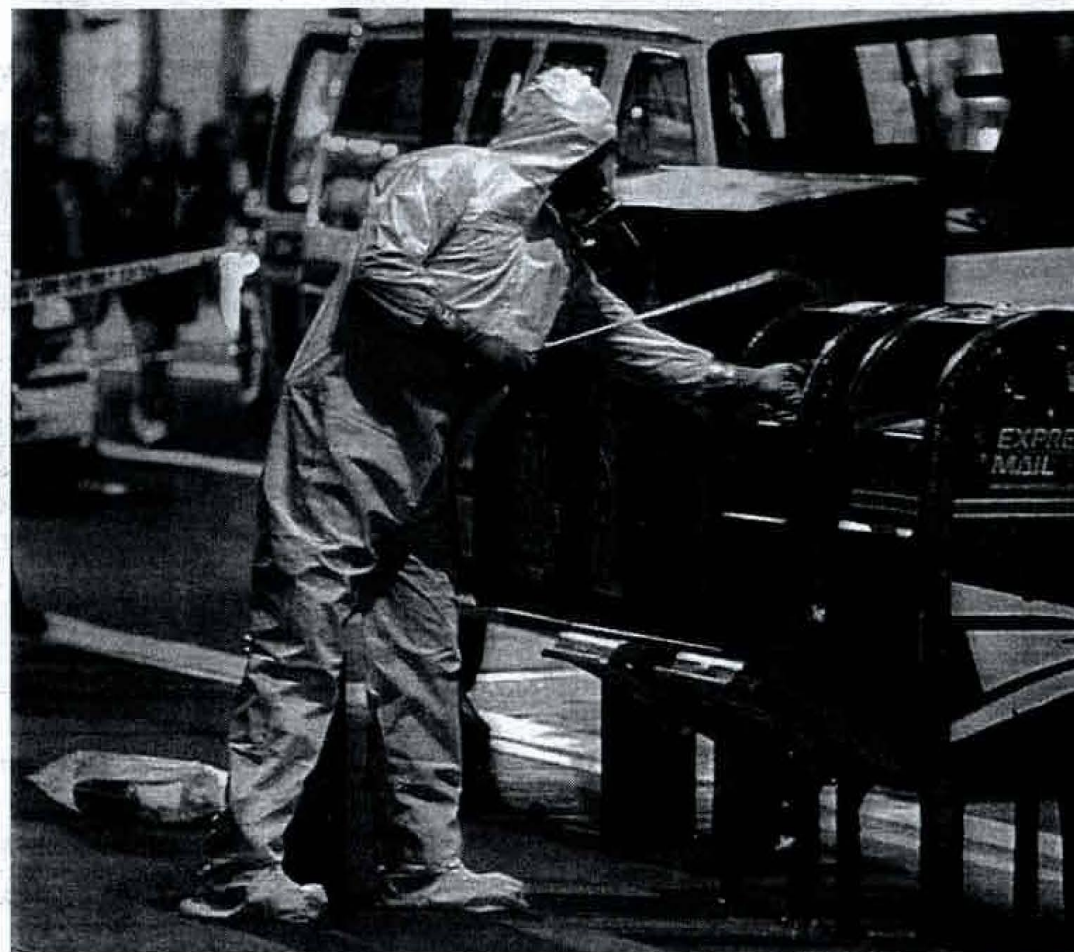
said that he knew of no comparable agreement at the federal level and that New York was ahead of other cities in trying to systematically sort through the roles of public health and law enforcement officials in a potential bioterrorist attack.

"This is in the public interest to do," Mr. Falkenrath said.

A copy of the internal protocol was provided to The New York Times. It provides for joint training of law enforcement and public health officials that is scheduled to start in January.

The agreement has not solved all outstanding issues. For instance, it does not state when and how quickly public health officials must notify the F.B.I. and police if they come across someone who may be infected with a dangerous germ. Officials said that law enforcement and public health officials were still discussing which germs should require immediate notification and joint investigations as part of a separate agreement, a so-called "annex" to the broader agreement.

According to a draft of the annex, the city's health department is to provide immediate notification of the detection of illnesses that could involve nine pathogens, including germs that cause anthrax, plague, and such virally induced, highly infectious diseases as smallpox and Ebola. But the Police Department is trying to broaden that list to include germs that also cause Q fever and tularemia, which though naturally occurring, have also been studied by several countries for use as potential weapons.



An emergency services police officer decontaminated a mailbox on Fifth Avenue in Manhattan in October 2001 after a suspected case of anthrax inhalation and about a dozen others became ill after contracting inhalation or skin anthrax that year.

Agreement on Joint Field Investigations Following Suspected Bioterrorism Incident

- Nov. 2004 agreement between NYC Dept. of Health and Mental Hygiene (DOHMH), NYPD, and New York Office of the FBI (at: www.cdc.gov/phlp)
- Represents a protocol formalizing mechanism to conduct joint public health and law enforcement investigations following a BT attack
- Agreement components
 - Legal references
 - Protocol assumptions and principles
 - Deployment parameters



NYC Agreement: Commissioner's Cover Letter

“Our agency takes its stewardship of confidential medical information very seriously. The trust that providers and the public have in the NYC DOHMH’s commitment to confidentiality and individual rights is crucial to our Agency’s success. This joint investigation protocol was conceived and concluded with this commitment firmly in mind.”



Joint Public Health – Law Enforcement Investigations: Model Memorandum of Understanding (MOU)

July 2008

Developed by:

**Public Health and Law Enforcement Emergency Preparedness
Workgroup**

Convened by:

**Centers for Disease Control and Prevention, DHHS
Bureau of Justice Assistance, USDOJ**

Model MOU for Joint Public Health and Law Enforcement Investigations

- Purpose:
 - This document provides factors and provisions for consideration for adoption by state, tribal, local, and other jurisdictions when developing methods for coordinating joint public health and law enforcement investigations of bioterrorism, suspected bioterrorism, or other public health concerns possibly resulting from deliberate, criminal actions.



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TIME



BIRD FLU

Is Asia
hatching
the next human
pandemic?



**Guide to Developing an MOU for
Coordinated Implementation of
Community Response Measures to
Pandemic Respiratory Disease**

In New Outbreak, Eerie Reminders of Other Epidemics

By LAWRENCE K. ALTMAN, M.D.

Spread of a mysterious respiratory illness to a number of Asian countries and Canada has led the World Health Organization to declare it "a worldwide health threat" — but little is known about the ailment.

The health organization calls the illness severe acute respiratory syndrome, or SARS. No one knows why it suddenly appeared or what causes it. So far, laboratory tests have told doctors only what it is not. And with the illness failing to respond to antibiotic and antiviral drugs, standard supportive nursing care and infection control measures seem the only treatment available.

No one can even say for sure how many people have come down with the disease. Health officials estimate SARS has caused at least 9 deaths among nearly 500 cases.

The uncertainty has fed unease.

Years of warnings about newly emerging diseases, not to mention bioterrorism, have left Americans jittery about rare and mysterious diseases.

Health officials have long predicted that influenza would strike again as it did during World War I in 1918 and 1919, causing 20 million deaths worldwide. SARS has revived those concerns just as the United States is on the verge of war with Iraq.

Its emergence now — especially because it seems to be striking young adults — is an eerie reminder of how diseases can affect military operations.

Health officials must confront two crucial questions: Is SARS an unknown form of a known disease like influenza? Or is it caused by a novel infectious agent? If past



Travelers wore protective masks as they arrived in Hong Kong yesterday.

outbreaks of new diseases are a guide, the answers may take time in coming.

Tick-borne Lyme disease was regarded as a new disease when it was given that name in 1977. It took four years after its detection in Connecticut to identify the causative agent, a spirochete bacterium, *Borrelia burgdorferi*, a microbe that had been identified for decades. For example, the same disease occurred as early as 1909 in Sweden.

After Legionnaire's disease struck in Philadelphia in 1976, it took six months before discovery of the causative bacterium, *Legionella pneumophila*. Meanwhile, researchers pursued many blind avenues, including toxins.

It took months to identify the Ebola virus

from outbreaks in Africa.

When the disease now known as AIDS was first identified in 1981, scientists debated whether it was caused by an infectious agent or a toxin. It took about two years to discover what is now known as H.I.V. And two additional years passed, to 1985, for general scientific acceptance that H.I.V. caused AIDS.

But in trying to solve the riddle of SARS, health officials have some advantages over the scientists who confronted these outbreaks. Laboratory techniques have become more sophisticated in recent years. The government has invested money to strengthen the public health system to improve the tracking of new and emerging infections. And since the Sept. 11 attacks the

government has invested additional money to improve the ability of state and local health departments to detect and prevent bioterrorism.

The researchers trying to unravel the SARS mystery will benefit from these public investments, but they still face a number of obstacles.

A logical first assumption was the possibility that the influenza virus — either a strain that had rarely infected people or one created by a major new mutation — caused SARS. Health officials say the only thing predictable about influenza is its unpredictability. New strains emerge regularly, and they vary widely in virulence.

Still, when health officials heard of the symptoms associated with SARS — fever, aches, difficulty breathing — they focused on avian flu, or flu spread from birds to people. In particular, they wondered about a rare strain known as A(H5N1).

The World Health Organization told health officials to look out for suspicious cases after the avian strain killed one person and sickened another in Hong Kong last month. And the same strain had infected 18 people in Hong Kong in 1997, killing 6.

The strain is lethal to chickens, but not to other birds like ducks. In 1997, Hong Kong officials ordered the slaughter of all of its 1.4 million chickens out of concern that the strain might cause an epidemic there and elsewhere.

But in recent weeks scientists at laboratories in at least five countries have failed to detect the avian flu strain in any SARS case. Dr. David L. Heymann, executive director in charge of communicable diseases for the W.H.O., said, "We have not ruled out influ-

Continued on Page 6

Legal, ethical factors tangle pandemic fight

By JEFF NESMITH
hjnsmith@ajc.com

Washington — Federal health officials preparing for a feared influenza pandemic said Tuesday that they are encountering unexpected legal and ethical complications.

In some places, for example, it is not clear who has authority to close schools in a pandemic. In others, administrators don't know at what "threshold of absenteeism" to send kids home.

Varying state laws and uncertainty among local school superintendents were cited during an Institute of Medicine meeting as examples of how unexpected consequences and unclear lines of authority could complicate efforts to control the disease.

The institute, an affiliate of the National Academy of Sciences, has a committee to review legal and ethical implications of pandemic response.

"We're hearing more and more from the states and the [U.S.] Department of Education that there needs to be clearer guidelines for closing the schools," said Centers for Disease Control and Preven-

tion epidemiologist Martin Cetron.

He said schools, because of their population density, could be prime breeding grounds for a rapidly spreading virus.

He showed a slide suggesting that if the average American family had about 60 guests, its home would be no more crowded than most schools on a normal day.

James Le Duc, who has coordinated CDC's pandemic response plan, said officials are discovering that "the landscape of state and local laws" dealing with many aspects of a pandemic is not clear. He said it's not clear that states will have legal authority to enforce federally imposed quarantines, for example.

Some scientists and law school professors attending the meeting warned of possible unintended consequences of decisions about how to allocate vaccines and antiviral drugs, impose quarantines, restrict travel and take other anti-pandemic measures.

"We may be able to take a perfectly manageable epidemic and turn it into a national disaster," said D.A. Henderson, a professor of public health and

medicine at the University of Pittsburgh.

Institute president Harvey Fineberg warned that it is not yet clear whether the federal Department of Health and Human Services or the newer Department of Homeland Security will be in charge "when the time comes."

Public health groups have argued that ultimate federal authority during a pandemic should be in the HHS, which includes CDC, the Food and Drug Administration, the U.S. Public Health Service and other health agencies.

However, the "National Response Plan" created by President Bush gives the Department of Homeland Security authority to coordinate all federal response to national incidents such as terrorist attacks and pandemics. Bush's "National Strategy for Pandemic Influenza" says the secretary of HHS will be in charge of health and medical responses to a pandemic.

"The worst thing in my nightmare is three different spokesmen coming up on Day One to explain why they're in charge," Fineberg said.

ABA JOURNAL



THE LAWYER'S MAGAZINE • NOVEMBER 2005

The Avian FLU TIME BOMB

Lawyers help prepare
for a possible outbreak
of this life-threatening
virus

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REHNQUIST REMEMBERED

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Page 50

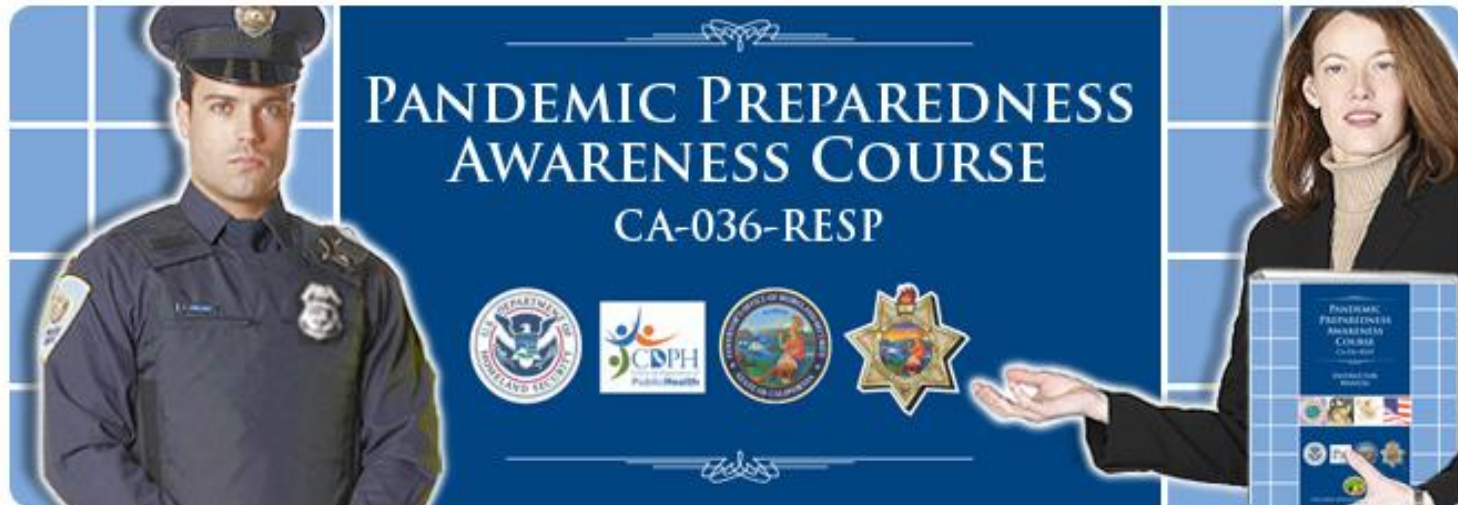
REHNQUIST'S EXPANDED ROLE

TAXPAYER SAVINGS TIME

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ToucanEd

[ABOUT TOUCANED](#)[CONTACT TOUCANED](#)**PUBLISHING • TRAINING • CONSULTING**

In response to requests to offer our Pandemic Preparedness Awareness Course this summer, ToucanEd is pleased to announce that the San Jose Police Department is hosting a training at their facility in San Jose, California. The course is designed for first responders, government employees, continuity planners, public health workers—all who wish to be certified as trainers of an awareness level course which you can later offer to your own organization at no cost.

This Course, CA-036-RESP, is certified by DHS/FEMA, the California Department of Public Health, and California Office of Homeland Security. It is also eligible for POST CPT credit under CNN 1212-20171-07. [See more information.](#)

This two-day training of trainers will be held on August 14th and 15th from 8:00 a.m. to 4:30 p.m.

Each participant will receive an Instructor Manual and a Participant Guide, eligibility to purchase Participant Guides for future trainings within their agencies, if desired; and license to duplicate materials for their in-house trainings.

Reserve your space today. A maximum of 30 individuals will be enrolled, and the cost is \$385 per person.

[Register online](#) for this course, or contact Stacie Del Giudice at (888) 386-8226, ext 17, to ask questions or make arrangements to host a course at your facility.

Coordinated Implementation of Community Response Measures (Including Social Distancing) to Control the Spread of Pandemic Respiratory Disease

***A Guide for Developing a Memorandum of
Understanding (MOU) for Public Health, Law
Enforcement, Corrections, and the Judiciary***

July 2008

Developed by:

**Public Health and Law Enforcement Emergency Preparedness
Workgroup**

Convened by:

**Centers for Disease Control and Prevention, DHHS
Bureau of Justice Assistance, USDOJ**

Guide to Developing an MOU for Coordinated Implementation of Community Response Measures

- Purpose:
 - To provide guidance for consideration by state, tribal, local, and other jurisdictions when addressing planning efforts to coordinate cross-sector implementation of community responses (including social distancing) to prevent or limit the spread of a severe, contagious respiratory disease such as pandemic influenza.



Guide to Developing an MOU for Coordinated Implementation of Community Response Measures

- Key sectors for coordination:
 - Public health
 - Law enforcement
 - Corrections
 - Judiciary



Guide to Developing an MOU for Coordinated Implementation of Community Response Measures

- Rationale for Guide:
 - “Even though the sectors represented on the Workgroup share overlapping responsibilities for the public’s health and welfare, in general and in most jurisdictions, they tend to operate in isolation from one another.”
 - “Recent emergencies and current disaster scenarios have changed this equation quite radically, to the point where it is difficult to imagine a severe pandemic influenza scenario that would *not* require the involvement of law enforcement, institutional corrections, community corrections, and the judiciary.”



Guide to Developing an MOU for Coordinated Implementation of Community Response Measures

- Scope:
 - Covers the set of community measures that would occur when a contagious disease (e.g., virulent influenza) already has reached pandemic status.
 - At this point, some measures (e.g., involuntary quarantine and isolation) would have limited, if any, indication because of the substantial spread of the disease in question.
 - Instead, public health officials and counterparts in other sectors will be relying on other measures that limit contact between people, (e.g., encouraging people to stay home from work and school and banning congregating in groups).



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Summary:

Intent of these MOU Tools

- Within a given jurisdictional setting (i.e., state, tribal, and/or local jurisdictions) to serve as a means to:
 - Bring to the table representatives of the relevant sectors,
 - Facilitate more complete understanding of each sector's roles and duties, in relation to the other sector(s) in preparing for and responding to certain types of public health emergencies, and
 - Accomplish these purposes in a manner that can be agreed upon by each sector and possibly viewed as binding.



Remaining Challenges

The Public Health and Law Enforcement Emergency Preparedness Workgroup

- Identifying jurisdictional-level gaps and impediments to effectively engaging public health with law enforcement, corrections, and the judiciary on improving coordination in preparedness for public health emergencies
- Fostering approaches for public health officials and other sectors to consider for incorporating these new tools and resources within their own jurisdictions' preparedness programs

For Additional Information on Public Health Law

All accessible at **WWW.CDC.GOV/PHLP**

- Compilation of public health legal preparedness resources
- National Action Agenda for Public Health Legal Preparedness
- “Public Health Emergency Law” Course
- *CDC Public Health Law News*

